

Unum Life Insurance Company of America LTC Department 2211 Congress Street, Portland, Maine 04122

## NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM Benefit Election Form

Long Term Care - Policy #510487

								LONG	y renn	Gai	e - Policy #31046/	
Your Name: (Last Name, First, Middle Initial)					Social Security Number Date of Birth (MM/DD/YYYYY)						f Birth (MM/DD/YYYY)	
Street Address					Gender  ☐ Male  ☐ Female			D	Date of Hire (MM/DD/YYYY)			
City, State, Zip Code					Home Telephone #			V	Work Telephone #			
Complete the following only if applicant is not the emple					( )				(		)	
Employee's N		applican				ity No		Employee Da	ata of Pirt	h	Employee Date of Hire	
Linployee's N	Employee Social						//		//			
Division (	☐ State Central Payroll				☐ All Others							
Applicant	ls:											
☐ Employee						Retiree						
☐ Employee's Spouse					Term	☐ Retiree's Spouse						
completed and	igned Authorizated you must be ap Check one)		or covera				the	Long Term (		n. 	enrollment kit, must be Plan 4A	
<ul> <li>Nursing Home Facility / \$3,000 Monthly Benefit</li> <li>Professional Home Care</li> </ul>		<ul> <li>Nursing Home Facility / \$3,000 Monthly Benefit</li> <li>Professional Home Care</li> <li>Total Home Care</li> </ul>				<ul> <li>Nursing Home Facility / \$3,000 Monthly Benefit</li> <li>Professional Home Care</li> <li>Simple Inflation</li> </ul>			t	<ul> <li>Nursing Home Facility / \$3,000 Monthly Benefit</li> <li>Professional Home Care</li> <li>Total Home Care</li> <li>Simple Inflation</li> </ul>		
<ul> <li>■ Plan 1B</li> <li>■ Nursing Home Facility / \$3,000 Monthly Benefit</li> <li>■ Paid Up Benefit</li> <li>■ Professional Home Care</li> </ul>		<ul> <li>■ Plan 2B</li> <li>■ Nursing Home Facility / \$3,000 Monthly Benefit</li> <li>■ Paid Up Benefit</li> <li>■ Professional Home Care</li> <li>■ Total Home Care</li> </ul>				<ul> <li>■ Plan 3B</li> <li>■ Nursing Home Facility / \$3,000 Monthly Benefit</li> <li>■ Paid Up Benefit</li> <li>■ Professional Home Care</li> <li>■ Simple Inflation</li> </ul>			t	■ Plan 4B ■ Nursing Home Facility / \$3,000 Monthly Benefit ■ Paid Up Benefit ■ Professional Home Care ■ Total Home Care ■ Simple Inflation		
Facility Be	nefit Duratio	n (Duratio	on of ber	nefits may	vary c	dependi	ng oi	n where bene	fits are re	eceive	ed.)	
(Check one)	☐ 3 Years							5 Years				
	ree or Spouse: Yomployer to make t				ugh th	e Emplo	oyee'	s payroll ded	uction. En	nploye	ee must sign below to	
	se select payment greement for Auto				natic P	ayment	s (de	ducted from y	your chec	king a	account – complete	
Billed directly (paper) by the insurance company: $\hfill\square$ Quarterly						•				nnually		
<u>Caution:</u> If yo your insurance		is Enrolln	nent For	m are inc	orrec	t or unt	rue,	we may have	e the righ	nt to d	leny benefits or rescind	
Impairment mu limitations and <b>MassHealth el</b> kit.	st occur after your exclusions apply t <b>igibility notice er</b>	effective of your covertitled "Fo	date of coverage. <u>Nassa</u>	overage ui MA Reside achusetts	nder th ents C Resid	his Long <u>)NLY:</u> \ lents Oı	g Teri You a nly"-	m Care plan i also signify t Form #7650	in order to that you I -04. All in	be con have in forma	or Severe Cognitive covered, and that certain received and read the attion is contained in your	
Your Premium	n: \$	(Tran	sfer the	premium	атоц	ınt fron	n the	calculation	on the ra	te sh	eet)	
			_//_		_			oyee's Signatu		_	///	
Applicant's Signature			Date	е		(Real	Emplo uired t	oyee's Signatui for Spouse Cov	re ⁄erage)		Date	
						ail all re	quir	ed signature	forms to			
	Retirees: P	lease sigr		ail all requ Retain a c		_			n (addres	s at t	op of page).	